



SIQ - 01252 (12-2015)

Republic of the Philippines
SOCIAL SECURITY SYSTEM
SICKNESS NOTIFICATION

CLAIM NO. _____

RE-FILING CLAIM NO. _____

THIS FORM MAY BE REPRODUCED AND IS NOT FOR SALE. THIS CAN ALSO BE DOWNLOADED THRU THE SSS WEBSITE AT www.sss.gov.ph

PLEASE READ THE INSTRUCTIONS AND REMINDER AT THE BACK BEFORE FILLING OUT THIS FORM. PRINT ALL INFORMATION IN CAPITAL LETTERS AND USE BLACK INK ONLY.

PART I - TO BE FILLED OUT BY THE MEMBER

A. PERSONAL DATA

SS NUMBER	COMMON REFERENCE NUMBER (IF ANY)	DATE OF BIRTH (MMDDYYYY)	TAX IDENTIFICATION NUMBER (IF ANY)
NAME (LAST NAME)	(FIRST NAME)	(MIDDLE NAME)	(SUFFIX)
ADDRESS (RM./FLR./UNIT NO. & BLDG. NAME)		(HOUSE/LOT & BLK NO.)	(STREET NAME)
(SUBDIVISION)		(BARANGAY/DISTRICT/LOCALITY)	(CITY/MUNICIPALITY) (PROVINCE) ZIP CODE
TELEPHONE NO. (AREA CODE + TEL NO.)	MOBILE/CELLPHONE NO.	E-MAIL ADDRESS	
FOREIGN ADDRESS (IF APPLICABLE)		COUNTRY	ZIP CODE

B. CERTIFICATION

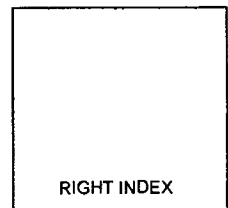
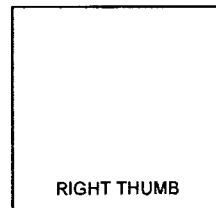
I certify that the information provided in this form are true and correct.

PRINTED NAME SIGNATURE DATE

If member cannot sign, affix fingerprints. Please read Instruction No. 6 of the form.

Below are the witnesses to fingerprinting:

1)	PRINTED NAME	SIGNATURE	DATE
ADDRESS & CONTACT NUMBER			
2)	PRINTED NAME	SIGNATURE	DATE
ADDRESS & CONTACT NUMBER			



PART II - TO BE FILLED OUT BY EMPLOYER

A. EMPLOYER DATA

EMPLOYER ID NUMBER	NAME OF EMPLOYER/REGISTERED BUSINESS NAME	E-MAIL ADDRESS
BUSINESS ADDRESS (NO. & STREET)	(BARANGAY)	(TOWN/ DISTRICT) (CITY/PROVINCE) ZIP CODE
START OF SICK LEAVE (MMDDYYYY)	NOTIFICATION FORM WAS RECEIVED BY US ON (MMDDYYYY)	E-NOTIFICATION DATE (MMDDYYYY)
		ACCIDENT/SICKNESS OCCURRED WHILE <input type="checkbox"/> Working <input type="checkbox"/> In Co. Premises <input type="checkbox"/> On Vacation <input type="checkbox"/> On Strike <input type="checkbox"/> Co. Shutdown <input type="checkbox"/> Under Suspension

B. CERTIFICATION

I certify that the above information are true and correct and that the reported accident/illness is duly recorded in the Employer's Logbook for EC Claim under page number _____ and entry number _____.

SIGNATURE OVER PRINTED NAME OFFICIAL DESIGNATION DATE
EMPLOYER/AUTHORIZED REPRESENTATIVE

PART III - MEDICAL CERTIFICATE (TO BE FILLED OUT BY THE ATTENDING PHYSICIAN)

BRIEF MEDICAL HISTORY AND PERTINENT FINDINGS

ATTENDING PHYSICIAN'S CERTIFICATION

I certify that I have seen and examined above-named patient on _____ (DATE) and in my opinion, confinement including recuperation period may last _____ days.
(no. of days)

DIAGNOSIS: FIT TO WORK: _____

PLACE OF CONFINEMENT <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL	START OF CONFINEMENT (MMDDYYYY)	NAME OF HOSPITAL (if confined in a hospital)
PRINTED NAME AND SIGNATURE		LICENSE NO.
ADDRESS OF PHYSICIAN'S CLINIC/HOSPITAL (NO. & STREET) (BARANGAY) (TOWN/ DISTRICT) (CITY/PROVINCE)		ZIP CODE

PART IV - TO BE FILLED OUT BY SSS PERSONNEL

RECEIVED BY (FOR MEMBER SERVICES SECTION)	RECEIVED BY (FOR MEDICAL EVALUATION SECTION)
SIGNATURE OVER PRINTED NAME DATE TIME	SIGNATURE OVER PRINTED NAME DATE TIME

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SS NUMBER/CRN (IF ANY)	NAME OF MEMBER (LAST NAME) (FIRSTNAME) (MIDDLE NAME) (SUFFIX)
RECEIVED BY	
SIGNATURE OVER PRINTED NAME	POSITION TITLE DATE & TIME SSS BRANCH

THIS PORTION TO BE FILLED OUT BY SSS PERSONNEL			
PART V - SCREENING RESULTS			
MEMBER SERVICES SECTION Screening was done and results are as follows: <input type="checkbox"/> In order <input type="checkbox"/> No signature of Employee <input type="checkbox"/> No signature of Employer <input type="checkbox"/> Medical Certificate not accomplished Remarks: _____		MEDICAL EVALUATION SECTION Screening was done and results are as follows: <input type="checkbox"/> In order <input type="checkbox"/> With findings, please see remarks Remarks: _____	
SCREENED BY _____ SIGNATURE OVER PRINTED NAME DATE TIME		SCREENED BY _____ SIGNATURE OVER PRINTED NAME DATE TIME	
RECEIPT AND SCREENING (RE-FILED CLAIM) <input type="checkbox"/> Claim accepted <input type="checkbox"/> Claim not accepted (see remarks)		REMARKS _____ _____	
RECEIVED AND SCREENED BY _____ SIGNATURE OVER PRINTED NAME DATE TIME			DATE RETURNED _____
PART VI - MEDICAL EVALUATION			
A. PHYSICAL EXAMINATION AND INTERVIEW			
PERTINENT PE FINDINGS (Member to affix signature after PEI)		Onset of Illness _____ Last Working Day _____ Back to Work _____ _____ Member's Signature	
B. RECOMMENDATION			
SS APPROVED # of days <input type="checkbox"/> Initial <input type="checkbox"/> Extension (indicate previous approval) _____ (In numeric) (In words) _____ (Inclusive Period) <input type="checkbox"/> Previous approval _____ <input type="checkbox"/> Hospital (Confined) _____ _____ (Date of Discharge) <input type="checkbox"/> PENDING - <input type="radio"/> For MFS <input type="radio"/> HCD/ODS referral _____ Initials Date <input type="checkbox"/> RETURNED - _____ Initials Date <input type="checkbox"/> DENIED - _____ Initials Date		EC APPROVED # of days <input type="checkbox"/> Initial <input type="checkbox"/> Extension (indicate previous approval) _____ (In numeric) (In words) _____ (Inclusive Period) <input type="checkbox"/> Previous approval _____ <input type="checkbox"/> Hospital (Confined) _____ _____ (Date of Discharge) <input type="checkbox"/> PENDING - <input type="radio"/> For MFS <input type="radio"/> HCD/ODS referral _____ Initials Date <input type="checkbox"/> RETURNED - _____ Initials Date <input type="checkbox"/> DENIED - _____ Initials Date	
REMARKS _____		REMARKS _____	
ILLNESS CODE/S _____			
EVALUATED BY _____ SIGNATURE OVER PRINTED NAME DATE		ENCODED AND RELEASED BY _____ SIGNATURE OVER PRINTED NAME DATE	

INSTRUCTIONS

- 1) Fill out this form in one (1) copy.
- 2) Always indicate "N/A" or "Not Applicable", if the required data is not applicable.
- 3) Please attach this notification to the Sickness Benefit Reimbursement Application.
- 4) Affix your initials on all alterations/erasures in this form.
- 5) Write SS Number and name of member in all the supporting documents submitted.
- 6) If member cannot sign, witnesses to fingerprinting shall be as follows:
 - Two (2) witnesses: One (1) witness is the employer/authorized representative and the other one (1) could be any person. Both should affix their signatures and indicate their addresses and contact numbers on the portions provided in Part I-B.

ATTACHMENT/SUPPORTING DOCUMENTS

For prolonged confinements/sickness

- Laboratory, X-ray, ECG and other diagnostics results
- Operating room/clinical record that will support diagnosis

For sickness that occurred while on strike/shutdown

- Certificate of Notice of Strike issued by DOLE
- Certificate of Foreclosure
- Certificate of Non-advancement of Payment from Employer

For vehicular accident w/ 3rd party involvement (EC claim)

- Police Report

ON FILING OF NOTIFICATION

For Employed Members

- To avoid penalties for late filing, Sickness Notification (SN) form must be submitted to employer within five (5) calendar days after start of confinement, except:
 - a) if confinement is in a hospital - deadline for notification is one (1) year from date of discharge
 - b) if sickness/injury occurred while at work or within company premises - Employer is deemed notified.
- For EC cases, sickness/injury must be recorded in the company logbook within five (5) calendar days from notice or knowledge of occurrence of the contingency. Failure to do so will mean employer liability to fifty (50) percent of the lump sum equivalent of the income benefit the employee is entitled.

For Employers

- To avoid penalties for late filing, employer may:
 - a) File the SN form at SSS within five (5) calendar days after its receipt from employee, including cases where sickness/injury occurred while at work or within company premises, or
 - b) Notify the system through the web and submit the SN form within thirty (30) calendar days after date of web notification.

REMINDER

Verification of status may be made thru the SSS Website at www.sss.gov.ph or contact our Call Center at 920-6446 to 55 or 917-7777.